1. Name of Employer _____

3. Summary of Transactions:

2. SHBP Location No.

County ___

STATE OF NEW JERSEY

DEPARTMENT OF THE TREASURY — DIVISION OF PENSIONS AND BENEFITS

NEW JERSEY STATE HEALTH BENEFITS PROGRAM

PO BOX 299, TRENTON, NJ 08625-0299

MONTHLY CHANGE SUMMARY

- See instructions on reverse side before completing this form -

This form is due in the Health Benefits Bureau by the 5th of each month for the coverage period beginning on the first of next month.

	a. Number of New Enrollment forms submitted: b. Number of Coverage Change forms submitted: c. Total forms submitted:			
	d. Number of deletions per Transmittal of Deletion form:			
	e. Number of rejected forms:			
4.	Signature of Certifying Officer			
	Date			
5.	PLEASE COMPLETE THE AREA BELOW I TRANSACTIONS ABOVE (#3). If you need 1, 2, and 4 on the additional form.			
	EMPLOYEE NAME	COVERAGE TYPE	EFFECTIVE DATE	TYPE OF CHANGE
_		· · · · · · · · · · · · · · · · · · ·		

MONTHLY CHANGE SUMMARY

INSTRUCTIONS

- 1. Self-explanatory.
- 2. Self-explanatory. (SHBP Location Number is indicted on the billing report.)
- 3a. Enter the total number of enrollment forms you are submitting with the Monthly Change Summary statement for employees you have enrolled for the first time in the Program.
- 3b. Enter the total number of enrollment forms reflecting coverage changes being submitted with the Monthly Change Summary statement.
- 3c. Enter the total number of forms indicated in items 3a. and 3b. of the summary statement.
- 3d. Enter the total number of employees you have identified on the Transmittal of Deletions statement whose coverage has terminated due to death, retirement, or termination. If there are no deletions in any month, please place a zero in this item do not attach a Transmittal of Deletion to the Monthly Change Summary statement.
- 3e. Enter the total number of employees who rejected coverage and submit their forms with the summary statement.
- 4. Please sign and date this form.
- 5. Self-explanatory.